Defining Medical Necessity: Challenges and Implications

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Introduction

The concept of medically necessary services is deeply imbedded in the Canadian medicare system, despite the fact that it seems to defy clear analysis. Coming to grips with this concept seems crucial to the sustainability of the system. Some commentators are concerned that the rapid development of new, and increasingly expensive, medical therapies will bankrupt any government that attempts to pay for all services deemed to be medically necessary. Others cite the fact that medications prescribed by physicians are not insured as inescapable evidence that the system needs expansion because it already is already failing to meet its promise of providing medically necessary therapy to all Canadians.

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In this brief paper I will take a critical look at the different ways the concept of "medical necessity" is used, and the work it does. I will focus, in turn, on each of the terms that make up the concept. My aim is not to provide the complete conceptual analysis which has eluded so many others. Instead I hope to illuminate the challenges that must be met if the concept is to continue to be useful in health care planning.

I. The Ambiguity of Medical Necessity

The term "medically necessary service" suggests *how* we decide that a treatment is necessary. Determinations of necessity are made by medical practitioners. This is clearest in the individual case where a medical doctor judges whether any treatment is necessary for this patient. A system set up in this manner puts great power into the hands of physicians – power over the patient and over the health care system.[1] The patient's access to government-funded services is controlled by her physician. The overall costs of the system are greatly influenced by these medical judgments.

To say that a service is medically necessary is also symbolically important: it is to say that the service is a necessity of a particularly important sort. An individual's *medical* necessity has a particularly strong claim on the public imagination. In the public mind medical necessity is in a class by itself, separate from any other necessity one might identify. It is a necessity which should not go unmet, even in an era of reduced government involvement is the provision of social services. If the government has an obligation to provide for any of the needs of its citizens, it surely has an obligation to meet medical needs. Any shift to a less evocative word risks losing this support for public payment.

II. The Beguiling Simplicity of Medical Necessity

Much of the discussion of medical *necessity* focuses on separating what is necessary from what is optional or elective. The analysis tries to distinguish people's genuine needs from their mere desires. Given that the patient has been accurately diagnosed as suffering from a condition (be it a crooked nose, infertility or erectile dysfunction), the question becomes: is it necessary for the condition to be treated? The very point of drawing this distinction is to decide whether treatment should be paid for out of the public purse. If only we can find the boundary between the necessary and the optional, we will have found a natural place to set the limit on what treatments are insured services. While most people are willing to help others meet their genuine medical needs through a publicly funded system,

fewer feel any obligation to help others satisfy all of their medical desires.

However, the move from the diagnosis of a condition needing treatment to an entitlement to insurance coverage for a treatment is often made too quickly. The fact that an individual has a need, even a medically diagnosed one, does not entail that the provincial health care plan has an obligation to pay for a particular treatment, or for any treatment at all.

Sometimes an obvious need exists but, unfortunately, medical science has no effective treatment to offer. Imagine a patient who suffers from a life-threatening disease for which no proven therapy exists. This patient's vital unmet need does not create an entitlement to unproven experimental medical procedures or alternative treatments paid for by the provincial health care insurance plan.

In other instances, one may grant that the patient's condition needs to be treated, and then recognize that medical science offers a variety of therapeutic options. In these cases it is misleading to speak of any particular medical intervention as the necessary one. Rather, the patient's condition necessitates treatment, but a number of different therapeutic modalities might be tried. Discussions of medically necessary treatment often overlook this point.

Recognizing that a patient's medical need might be met in a number of different ways opens up the conceptual space within which Alberta's controversial *Health Care Protection Act*[2] operates. Under this legislation, all Albertans who suffer from a condition that necessitates medical services will receive treatment – and they will receive it regardless of their individual ability to pay. However, some patients may choose to purchase a treatment that is "enhanced"; that is, one which exceeds "what would normally be used in a particular case in accordance with generally accepted medical practice."[3]

Critics view this legislation as a logical sleight of hand designed to circumvent the spirit, if not the letter of the *Canada Health Act*.[4] Under this scheme, Canadians will be paying for medical treatment that they need. For these patients medical treatment is necessary, even if the particular treatment they receive is not. But from another perspective, the provincial health care plan is doing just what is required of it. No one in medical need faces a financial barrier that keeps them from treatment which alleviates the need. To be sure, the person who is unable or unwilling to pay may not get the best treatment available.[5] But then, it is not clear that the publicly funded health system must always provide the best treatment available.

Is the Current System Sustainable?

The current system is under pressure from a variety of directions. Much of the pressure comes from challenges to the concept of medical necessary services.

Patients are more inclined to take charge of their own care. On the one hand, the notion that there exists an identifiable set of "medical needs" is openly questioned in many circles. Within bioethics, the very idea that a physician could determine what a patient needs is likely to be portrayed as a remnant of the bad old days of medical paternalism.[6] And according to a fashionable postmodern critique, needs—even medical needs—are a social construct whose construction should not be left in the hands of a dominant profession such as medicine. On the other hand, the physician is no longer the only source of information about treatment options. The internet puts an enormous assortment of information at the fingertips of the potential consumers of medical goods and services. Producers of drugs use direct-to-consumer advertising (often streaming over the border) to provide information and create demand. The result of these developments is that patients/clients are more likely to arrive at the clinic door having already determined what is necessary for them and seeking only the physician's validation of their choice.

Other care providers, both those in recognized health care professions and those who are less organized, chafe at the exclusion of the services they provide from insurance coverage. They argue that the services they provide are necessary but not medical.[7] Therefore, they would like to see the publicly funded health care system expanded to include care which is neither a medical service nor ordered by a medical doctor.

Funders often view the physician's discretionary authority to determine whether treatment is necessary as the Achilles heel of the system. There is a danger that preserving this discretion to practitioners could break the bank. This might come about in either of two ways. First, practitioners might judge a treatment to be required because it is profits them to provide the service, rather than because it ameliorates the patient's real need.[8] But there seems to be little evidence that Canadian physicians typically act as self-interested income maximizers. The professional ethic which enjoins the physician to consider first the patient's welfare has, it seems, maintained a robust hold over physicians' behaviour. But this professional ethic also has a tendency to add expense to the system, for it often is expressed in maximizing terms. Physician are commended not only to put their patient's interests above their own, but also to place the patient's

interests above the interests of the health care system. Optimal outcome for the patient should be the physician's overriding concern, according to this view. Regardless of the root cause, the result is ever increasing costs, and the obvious solution is to insert some check on the physician's authority.

In the face of these criticisms it is tempting to jettison the concept of medical necessity, but that seems ill-advised since it risks sacrificing the strong public support our current system enjoys. A better tack is to meet these challenges on their own terms. Those who would like to see government funding for services which meet needs other than those recognized by modern medicine can propose a complementary system.

The determination of what is acceptable medical practice—both the setting of the general standard of care and its application to the patient's particular circumstances—must remain in the hands of the medical profession. Any alternative system threatens to undermine both the patient's trust that he is receiving appropriate care and the physician's confidence that she can provide quality medical care in Canada.

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1. I leave aside one complication. The current system also pays for treatments provided in hospital. Since medical practitioners control entrance to hospital, in an important sense, access to these services is also controlled by medical practitioners.
2. R.S.A. 2000, c. H-1.
3. *Ibid.*, s. 29(f).
4. R.S.C. 1985, c. C-6.
5. I assume that an "enhanced" treatment must be better in some essential than what normal medical practice would offer.
6. This is most clearly seen in the last decade's debates over the related issue of the physician's authority to withhold "medically futile" treatment.
7. Whether these services should be seen as complementary to medicine or competitors with it is not an issue we need to engage here.
8. Many critics of the *Health Care Protection Act*, *supra* note 2, raise a similar alarm about services offered directly to patients. They argue that physicians with financial interests in facilities will recommend "enhanced" medical services which offer no real benefit in comparison with the generally accepted therapy.